# Prevalence of PTSD, complex PTSD and the nature of trauma experiences in a sample of clients with a diagnosis of Emotionally Unstable Personality Disorder accessing complex needs services

NHS
South West London and St George's Mental Health NHS Trust

## Introduction

Whether complex PTSD can be considered a distinct diagnosis amongst those with diagnoses of both EUPD and PTSD has been the focus of recent research due to high similarity in presentation (see Table 1). Using latent class analysis, Cloitre and colleagues (2014) determined that the two disorders are in fact distinct profiles. What remains unclear is whether these similar, yet distinct disorders can co-occur within the same individual, and if so, to what extent? There is a high incidence of trauma amongst individuals with a diagnosis of EUPD, with persistent invalidation being a key biosocial factor in the disorder's aetiology (Linehan, 1993). The current study investigated the prevalence of PTSD and cPTSD in a sample of patients accessing specialist outpatient treatment for EUPD, in addition to the nature of their traumatic experiences. The current prevalence of PTSD and cPTSD in community samples is estimated at 5% and 14% respectively, rising to 12% and 61.1% respectively in clinical samples of individuals seeking help for trauma related symptoms (Cloitre et al. 2018). The prevalence of cPTSD is predicted to be the same, if not higher, for the current sample as for previous clinical samples.

| | EUPD | CPTSD |
|---|---|---|
| Emotional regulation | Emotional lability<br>Extreme uncontrolled anger<br>Profound emotional dyscontrol | Chronic difficulties in self-calming when distressed<br>Chronic emotional numbing |
| Self-concept | Unstable and fragmented sense of self | Negative sense of self<br>Chronic sense of guilt<br>Shame and worthlessness |
| Relationships | Volatile relational hostility<br>Alternating enmeshment and disengagement to avoid real or imagined abandonment | Avoidance and detachment based on fear of closeness |

Table 1.

## Methods

The International Trauma Questionnaire (ITQ) and International Trauma Exposure Measure (ITEM) were used to collect data around trauma-related symptoms and the nature of traumatic experiences. 25 clients of a specialist complex needs service with a confirmed diagnosis of EUPD returned completed questionnaires. EUPD diagnoses were confirmed through structured clinical interviews with qualified staff. The ITQ and ITEM questionnaires were given either electronically or in paper form by individual assessors and data was collated using Microsoft Excel. Analysis of descriptive statistics and linear regressions were conducted to identify the relationship between the number of traumatic events experienced by an individual and the odds of meeting criteria for a diagnosis of PTSD or cPTSD. Questionnaire data was collected from routine outcome measures as part of a service evaluation project, so ethical approval was not required.

## Results

Complete data was obtained for 23 of the 25 participants.15 of the 23 participants met criteria indicating a diagnosis of either PTSD (13%, n=3) or CPTSD (52%, n=12) (Figure 1.). All 25 participants who completed the International Trauma Exposure Measure had experienced at least one traumatic event. The mean number of traumatic experiences was 10 (r=15). The most commonly experienced traumatic event being emotional abuse in the form of 'being repeatedly humiliated, put down, or insulted by another person', which 21 of the 25 participants had experienced, before physical assault by someone other than a parent/ guardian, which 20 of the 25 had experienced (table 2)

The odds of meeting criteria indicative of a diagnosis of PTSD were increased by 1.54 for every one-unit increase in the number of traumatic events experienced (95% CI 0.98, 2.42, $p = 0.06$). With 10 traumatic experiences the probability of developing PTSD is 0.62.

The odds of meeting criteria indicative of a diagnosis of cPTSD were increased by 1.71 for every one-unit increase in the number of traumatic events experienced (95% CI 1.01, 2.89, $p = 0.05$). With 10 traumatic experiences the probability of developing cPTSD is 0.43.

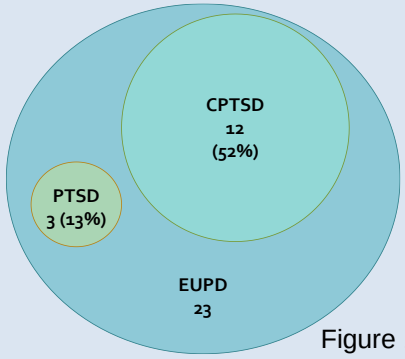


Figure 1.

## Discussion

Of our sample of 23 participants, 15 met criteria indicating a potential diagnosis of either PTSD (13%, n=3) or cPTSD (52%, n=12). The prevalence of cPTSD is lower amongst our caseload of clients with EUPD diagnoses compared to previously investigated clinical samples of trauma exposed individuals (Cloitre et al. 2018). This lower prevalence is despite the higher mean number of traumatic events experienced by the current sample (10 events), compared to clinical samples of help-seeking individuals (7 events) and may be reflective of pathology being more accurately captured by the diagnosis of EUPD. In terms of limitations, the use of a validated diagnostic measure such as the PCL-5 rather than the self-report ITQ would have increased our confidence in our results and conclusions. Furthermore, there were some issues with missing data due to how paper forms were completed that could be resolved through using only online questionnaires.

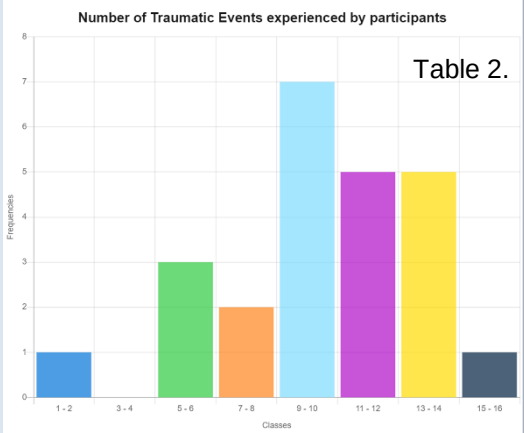


Table 2.

## Clinical Applications

The current study draws attention to the high rates of traumatic experiences and trauma-related symptoms in samples of people who meet criteria for a diagnosis of EUPD. Though not all individuals who meet criteria for a diagnosis of EUPD have experienced trauma, if the current sample is representative of this population, then we can assume that those accessing specialist services will have and will want treatment that addresses their trauma-related symptoms. It is therefore our responsibility in providing trauma informed care to ensure we screen for a history of trauma, and for trauma-related symptoms. Furthermore, incorporating trauma work into stage 3 stepdown work is often offered within our service, however this is dependent upon the individual therapists training. Staff working with individuals with a diagnosis of EUPD should be given funding to attend relevant training so target these symptoms and comorbidities, such as DBT-PTSD. The similarities in aetiology and expression of distress in cPTSD and EUPD, and the high prevalence of cPTSD within EUPD samples, evokes the need for conversation on whether EUPD should be considered as a trauma diagnosis. Not only would this view have destigmatising for service users, it may also encourage clinicians to garner willingness to work with this often overlooked and dismissed population.

## References

Cloitre, M., et al. "The International Trauma Questionnaire: Development of a Self-Report Measure of ICD-11 PTSD and Complex PTSD." Acta Psychiatrica Scandinavica, vol. 138, no. 6, 3 Sept. 2018, pp. 536–546, 10.1111/acps.12956. Accessed 3 Mar. 2020.

Cloitre, Marylène, et al. "Distinguishing PTSD, Complex PTSD, and Borderline Personality Disorder: A Latent Class Analysis." European Journal of Psychotraumatology, vol. 5, no. 1, 15 Sept. 2014, p. 25097, 10.3402/ejpt.v5.25097.

Linehan, M. M. (1993). Dialectical behavior therapy for treatment of borderline personality disorder: implications for the treatment of substance abuse. *NIDA research monograph*, *137*, 201-201.